Dermatopathology Form

Advanced Clinical Laboratories
"Focusing on Anatomic Pathology"
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LAB USE ONLY

DP 01001

CLIENT INFORMATION

Patient Last Name	First Name	MI	DOB (MM/DD/YEAR)	Age	Sex	Social Security #
					☐M ☐F	– –

Patient Home Address	Apt.#	City	State	Zip	Home Phone	Alternative Phone
					( ) --	( ) --

Bill To: ☐ Client ☐ Patient ☐ Insurance ☐ Medicare (ABN) signed ☐ Medi-Cal (Attach POE) ☐ Work Comp ☐ HMO/IPA Authorization Number: _____

Patient is: ☐ Subscriber ☐ Spouse ☐ Dependent ☐ Other _____

Primary Ins. Name _____ ID# _____ Group # _____

Secondary Ins. Name _____ ID# _____ Group # _____

Employer's Name _____ City _____ Tel ( ) -

Please attach front and back copies of insurance card(s).

Patient's Reference ID:

Ordering Physician's Name:

NOTE: WHEN ORDERING TESTS FOR WHICH MEDICARE OR MEDI-CAL (MEDICAID) REIMBURSEMENT IS SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF A PATIENT, RATHER THAN FOR SCREENING PURPOSES.

COLLECTION INFORMATION / DIAGNOSIS CODE(S)

Collection Date: ____/____/____ Time: ____:____ AM PM # of Vials: ____

ICD-9 Code/DX 1	ICD-9 Code/DX 2	ICD-9 Code/DX 3	ICD-9 Code/DX 4

Patient History: _____

IMMUNOFLUORESCENCE (IF)

☐ Direct IF (Skin, Oral Mucosa.....) ☐ Indirect (serum) ☐ Salt Split

SPECIMEN SITE	SPECIMEN TYPE & ORDER	CLINICAL DIAGNOSIS / IMPRESSIONS
Specimen #1 _____	☐ P ☐ SH ☐ SN ☐ E ☐ PAS ☐ CM ☐ DIF ☐ AS	Specimen #1 _____
Specimen #2 _____	☐ P ☐ SH ☐ SN ☐ E ☐ PAS ☐ CM ☐ DIF ☐ AS	Specimen #2 _____
Specimen #3 _____	☐ P ☐ SH ☐ SN ☐ E ☐ PAS ☐ CM ☐ DIF ☐ AS	Specimen #3 _____
Specimen #4 _____	☐ P ☐ SH ☐ SN ☐ E ☐ PAS ☐ CM ☐ DIF ☐ AS	Specimen #4 _____
Specimen #5 _____	☐ P ☐ SH ☐ SN ☐ E ☐ PAS ☐ CM ☐ DIF ☐ AS	Specimen #5 _____
Specimen #6 _____	☐ P ☐ SH ☐ SN ☐ E ☐ PAS ☐ CM ☐ DIF ☐ AS	Specimen #6 _____
Specimen #7 _____	☐ P ☐ SH ☐ SN ☐ E ☐ PAS ☐ CM ☐ DIF ☐ AS	Specimen #7 _____
Specimen #8 _____	☐ P ☐ SH ☐ SN ☐ E ☐ PAS ☐ CM ☐ DIF ☐ AS	Specimen #8 _____

ADDITIONAL TEST REQUESTS / INFORMATION / INSTRUCTIONS

*Additional testing may be performed if determined to be medically necessary to render a diagnosis in the opinion of the reviewing pathologist at additional cost.

Special Instructions: _____

KEY: P = Punch SH = Shave SN = Snip E = Excision PAS = Fungal CM = Check Margins DIF = DIF AS = Alopecia Sections

DP 01001 (1)	DP 01001 (2)	DP 01001 (3)	DP 01001 (4)	DP 01001 (5)	DP 01001 (6)	DP 01001 (7)	DP 01001 (8)

Physician's Signature: _____ **Date:** ____/____/____

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* Beneficiary's signature is required on reverse side.